Montana State Library
3 0864 1004 9787 7

362.2905
A35H
1991
SPR

THE HABIT

ALCOHOL & DRUG ABUSE DIVISION
Montana Department of Institutions
1539 11th Avenue, Helena, MT 59620
(406) 444-2827

Darryl L. Bruno, Administrator
Norma Boles, Standards & Quality Assurance
Ken Taylor, Prevention
Nancy Tunnicliff, Program Evaluator
Marcia Armstrong, Prevention & Planning
Phyllis Burke, Certification & Training
Karen Goans, Program Evaluator

STATE DOCUMENTS COLLECTION
AUG 26 1992
MONTANA STATE LIBRARY
1515 E. 6th AVE.
HELENA, MONTANA 59620

Quarterly Publication

Spring 1991

+ + + + + + + + +

DEPARTMENT REORGANIZATION

The Department of Institutions has reorganized and is now composed of five divisions: management services, the human service delivery systems of mental health, alcohol and drug abuse, and corrections, the residential component of the developmentally disabled human service delivery system and a veteran's nursing home program. The majority of the reorganization involves the former Treatment Services Division. The division, previously composed of the Mental Health Bureau and the Chemical Dependency Bureau will no longer exist. The Mental Health Bureau will now be a separate Mental Health Division. The Chemical Dependency Bureau has become the Alcohol and Drug Abuse Division and the other services (developmental disabilities residential programs and the veteran's nursing program) formerly provided by Treatment Services will be in the Special Services Division. Both the Corrections and Management Services Divisions remain the same. This reorganization will better enable the Department to administer a continuum of services from community programs to institutional programs within each human service system.

The Alcohol and Drug Abuse Division is responsible for the development and management of a comprehensive alcohol and drug abuse system which provides detoxification, diagnosis, treatment, and referral services for persons suffering from alcohol and drug addiction. The Division assures the availability of alcohol and drug abuse treatment services for those who would otherwise be unable to pay. This system is currently comprised of a residential component, the Alcohol Service Center and Lighthouse Drug Treatment Program located on the Galen campus of the Montana State Hospital, and community alcohol and drug treatment services that are contracted through local agencies and individuals. The division administrator is Darryl Bruno, former bureau chief of the Chemical Dependency Bureau.

This reorganization has been approved by the Governor and became effective October 1, 1990.

+ + + + + + + + +

NEW TOLL-FREE NUMBER 1-800-45-RADAR

This number provides a prevention clearinghouse for Montana and will provide information, pamphlets and answer questions regarding prevention and treatment. An answering machine will be connected soon for day or night assistance.

+ + + + + + + + +

RULES AND REGULATIONS UPDATE

The revised rules and regulations have been distributed to all Approved Chemical Dependency Programs statewide. Please update your policies and procedures pursuant to the revisions. The areas revised include client rights, chemical dependency educational courses - ACT program, outpatient component - requirements for assessment by a certified chemical dependency counselor and certification.

The evaluation process will ensure the revision of applicable policies and procedures.

Efforts are underway to expand all components to include utilization review standards and add an intensive outpatient component. As rulemaking is a time consuming process, promulgation of this expansion will not occur before June of 1991.

+ + + + + + + + + +

BILLS SIGNED BY THE GOVERNOR AS OF APRIL 28, 1991

HB 102 **eff. date 10/1/91**	Eliminating the requirement that mandatory treatment for DUI offenses be provided only through approved treatment programs; allowing mandatory treatment for DUI offenses to be obtained from any certified chemical dependency counselor.
HB 455 **eff. date 7/1/91**	Indefinitely extending the certificate of need law by repealing the expiration date of the law.
HB 521 **eff. date 10/1/91**	Providing that the Department of Institutions has the duty and responsibility to assist interested agencies and organizations in developing education and prevention programs for chemical dependency.
HB 668	An act making revocation of a driver's license mandatory for a person under 18 years of age convicted of multiple offenses of possession of an intoxicating substance.
HB 831 **eff. date 10/1/91**	Authorizing the Department of Institutions to adopt standards governing the approval of chemical dependency treatment programs and rules governing the use of countywide treatment plans in determining county needs for treatment, rehabilitation, and prevention of chemical dependency.
HB 848 **eff. date 7/1/91**	Changing the name of the Department of Institutions and the Director of Institutions to the Department and Director of Corrections and Human Services; defining the components, purpose, powers, and duties of the Department.
HB 909 **eff. date 7/1/91**	Relating to certification of chemical dependency counselors and persons providing counseling for gambling addictions; establishing requirements for certification of chemical dependency counselors; providing for suspension or revocation or certification for violation of professional ethics standards; requiring a study of the minimum requirements for certification of persons providing counseling for gambling addictions.
HB 966 **Transmit to Governor**	Creating a committee on the Montana State Hospital and at Warm Springs, directing that the committee conduct a study of the past, current, and potential future uses of the Montana State Hospital; requiring the committee to report the study's findings to the 53rd Legislature; appropriating funds for conducting the study; and providing effective dates.
SB 140 **eff. date 10/1/91**	Include anabolic steroids as a Schedule III drug; providing a misdemeanor penalty for first offense possession of anabolic steroids.
SB 49 **Transmit to Governor**	Creating the offense of criminal sale of dangerous drugs on or near school property; providing penalties; creating an affirmative defense.

+ + + + + + + + + +

OFFICE OF TREATMENT IMPROVEMENT
JUVENILE AFTERCARE GRANT

Boyd Andrew Chemical Dependency Care Center of Helena has been awarded the largest single federal grant to a chemical dependency program in the history of the state. The grant, money totaling $687,000.00 over three years will be used as seed money to start a Transitional Living Facility for adolescent males and an Intensive Outpatient Program for adolescents.

The halfway house is situated on 10 acres near Helena and incorporates mini wilderness experiences as well as intense job training into the traditional halfway house experience. The new Transitional Living Facility opened for business 12-18-90 and is accepting referrals for males aged 12-22 who have successfully completed Inpatient treatment.

Fur further information contact Mike Ruppert at 443-2343.

+ + + + + + + + + +

Recovery Northwest will be honoring **Karen Bolles Marvel** for 14 years of continuous service. Karen was one of the original Board Members of Recovery Northwest in 1975 and went on to become a counselor on November 30, 1976 when the Eureka Office was opened as a satellite of Recovery Northwest, and she has been there ever since. Karen was certified by the Department of Institutions, State of Montana in 1982.

Karen is a delightful person, competent counselor and an asset to the community she serves.

+ + + + + + + + + +

COMMUNITY PARTNERSHIP GRANTS

HHS Secretary Louis Sullivan and Drug Policy Director, William Bennett announced the award of 95 community partnership demonstration grants, totaling about $42 million over the 15 months. The grants, awarded by the Office for Substance Abuse Prevention, have a project period of five years with grantees coming back for continuations annually.

Two grants were awarded in Montana to the Montana Health Professional Education Foundation, Inc. of Bozeman and the Blackfeet Community College in Browning.

The grants are designed to help communities plan and implement comprehensive, coordinated prevention programs aimed at stopping or reducing drug and alcohol use. Under terms of the program, the awards went to local public and private coalitions or partnerships with a minimum of seven member organizations that may represent healthy education, law enforcement, housing or other human services - one of which must be a local government entity. The partnerships, in turn, are to involve grass roots community groups, religious institutions, business and industry, physicians, educators, media representatives and family, parent and youth groups, in developing comprehensive long-range drug and alcohol abuse prevention activities.

+ + + + + + + + + +

CDPM NEWS

The annual conference was a resounding success. Terry Gorski presented a workshop that was controversial. He challenged the validity of recent popular trends in the field (ie: Addictions model and Co-Dependency). He encouraged attendees to take a stand against methods and ideologies that threaten the very existence of the field.

Gorski's workshop was timely to CDPM's legislature agenda in that he attributes the trends in the insurance industry (less coverage and reimbursement) as their reaction to abuses resulting from the newer treatment models (ie: <u>everyone</u> has the potential for inpatient treatment). Indeed all of CDPM's legislative efforts will be directed toward the insurance industry (ie: increase coverage limits, regulate managed care organizations, and allow fair competition to provide services to PPD organizations). CDPM had been working on a bill which would allow the Department of Commerce to enforce a Code of Ethics and thereby define the areas Certified Chemical Dependency Counselor is competent to treat, however recently discovered missed administration deadlines associated with this type of legislation will have to wait until the next session.

KAREN GOANS - PROGRAM EVALUATOR

When I was asked to write my story to introduce myself as the new Project Evaluator for the Alcohol and Drug Abuse Division I debated on where to begin? What got me into this sometimes crazy business of chemical dependency. My own belief is that as the product of two alcoholic parents growing up in a small, hard drinking, hard working community in the Upper Peninsula of Michigan I began learning about the disease at birth. As the oldest child in a very dysfunctional family I was statistically one of those most likely to want to "help others" by making a career in human services. I was also a sitting duck for developing my own dependency. In 1974 I found myself in a treatment center dealing with my own alcoholism.

Contrary to many people coming out of treatment, being a counselor was the last thing I was planning to do with the rest of my life. My treatment counselor, very wisely, sent me to a halfway house and it was during my residency there that counseling sort of found me. Not knowing what I did want to do with my life, I began attending some college courses and workshops on chemical dependency in hopes that I would not only better understand myself but also to learn how to "save" those members of my family still untreated. I went through my Crusader Rabbit syndrome for about 6 months. When it became apparent that none of those untreated family members were interested in my "saving" them, I altered my goal to something more realistic and less grandiose and earnestly began training to be a counselor in hopes of having a positive effect on someone and in 1977 became a certified counselor in Michigan.

My first job, ironically, was as manager of the very same halfway house I once lived in. When the house closed due to lack of funding (and you thought that problem was new) I decided to try inpatient treatment for a while. From 1978 through half of 1981 I functioned as a Unit Counselor at the Hazelden Foundation in Center City, MN. Some painful personal events led to a decision to leave the midwest. Truthfully, Montana was probably the last place I had in mind. As I was tired of winters I was hoping for a southern climate, something more along the lines of sun and sand not snow and cold. However, as many of us tell our clients, we get what we need and not what we always want. So, on June 1, 1981, I found myself living in Great Falls helping give birth to the Chemical Dependency Unit at Montana Deaconess Medical Center. Although I'm still tired of winters and prefer wearing shorts to parkas and Sorels, I can't imagine living anywhere else but Montana.

In the summer of 1982, I was invited to help open a treatment center in Plymouth, England. At the time I was single and into adventures, so why not. September of that year found me aboard a Polish transatlantic ferry with all my worldly possessions bound for what I now call my tour of duty in the foreign service. After spending the next 10 days desperately, and nearly succeeding, to die of seasickness I swore I'd never set foot on another boar as long as I lived. To describe my year in England would take a book. Let if suffice to say it was an interesting learning experience. Jim Jensen, who I'm sure some of you know from his days at Rimrock and now in private practice in Billings, was the Program Director at the Center called Broadreach House. He, his wife and I commiserate regularly about our days on the other side of the Atlantic. Guess how I came home? Yup, the same Polish Transatlantic Ferry. It was, kind of like, what is said about childbirth - you forget the pain until you decide to do it again. Well, only 2 children and 2 trips across the Atlantic on the R.S.S. Stafan Batory is sufficient for me. I have a whole new appreciation for the pilgrims aboard the Mayflower.

Since I had found a sense of belonging in Montana, I returned here and once again found myself involved in a new program. From August 1983 to January 1984, I worked with John Brekke and the Wilderness Treatment Center in Marion. After sliding on black ice and rolling my car on the way home from work one evening, I figured I was too old for ranch life and returned to the Deaconess program in Great Falls where I had stayed put in various positions, most recently as Outpatient/Training Coordinator, until June 29th of this year.

I was meant to return to Great Falls as 6 years ago that is where I met and married my husband Dan who is also in the counseling business currently supervising the Boyd Andrew Transitional Living Center. He said I should also mention what a great guy he is. I can honestly say that life has changed for the better in the past 6 years. Non-pathological co-dependency is great!

After being involved in some form of direct client care for 15 years, I decided it was time to switch gears. I applied for and was hired in the position most recently occupied by Fred Fisher. I'm thoroughly enjoying working with the gang at ADAD and as I'm traveling the state on evaluations getting to meet many of you who were once only voices on the phone. I'm looking forward to meeting the rest of you in the coming months.

STAY SMART!!
PREVENTION CORNER

Marcia Armstrong

FRED FISHER APPOINTED DRUG ABUSE COORDINATOR

The Department of Justice has appointed Fred Fisher to the post of Drug Abuse Prevention and Education Coordinator for the State of Montana. Fisher's primary responsibility will be to coordinate and promote the D.A.R.E. (Drug Abuse Resistance Education) Program throughout the state. The D.A.R.E. Program uses law enforcement personnel to teach children to avoid drug abuse.

In addition, Fisher will develop and implement a clearinghouse for information about drug abuse, prevention, education and treatment; he will also serve as a liaison between the Department of Justice and local, regional and national prevention organizations. His other duties will include facilitating the development and coordination of prevention programs throughout Montana.

During the coming weeks and months, Fisher will be attempting to contact as many of you as possible. Please feel free to contact him at 444-2026. He is available Monday through Friday, from 8:00 a.m. to 5:00 p.m. The mailing address at the Department of Justice is - 215 North Sanders, Helena, MT 59620-1401.

+ + + + + + + + + +

DRUG ABUSE RESISTANCE EDUCATION PROGRAM EXPANDS

According to Fred Fisher, Drug Abuse Prevention and Education Coordinator for the Department of Justice, the Montana Board of Crime Control has awarded grant money to initiate six new Drug Abuse Resistance Education (D.A.R.E.) programs throughout the state. The grants for the new programs were made available through Anti-drug Abuse Act money administered by the Montana Board of Crime Control. With the addition of two other programs initiated by the schools in Broadwater and Meagher counties, Montana school children now receive D.A.R.E. instruction from twenty-one programs throughout the state. During the 1989 school year, approximately four thousand children received the D.A.R.E. message. The new programs will enable the curriculum to be taught to an even larger number of students.

The new programs are located in the coal counties of southeastern Montana as well as the counties of Deer Lodge, Granite, Powell, Sweetgrass, Ravalli and the community of Valier. Additionally, the Blackfeet tribe and the Assiniboine-Sioux tribes received grant money.

According to Attorney General Marc Racicot, these new programs demonstrate the strong commitment of both the Department of Justice and the Montana Board of Crime Control to the development of a comprehensive strategy to combat drug abuse in Montana. Racicot views prevention and education as a critical component of Montana's response to the drug problem.

The D.A.R.E. program uses uniformed officers to teach children about drugs and how to resist peer pressure to abuse drugs. There are currently thirty five Montana law enforcement officers certified as D.A.R.E. instructors. Estimates are that there are more than 7000 D.A.R.E. officers nationwide.

+ + + + + + + + + +

CLINICS AND TREATMENT CENTERS across USA are adopting the new CENAPS Model of Relapse Prevention Therapy to help relapse-prone chemically dependent people who couldn't be helped before....Certification as a trained relapse prevention specialist helps clinician improve treatment and professional status....Contact: Terence T. Gorski, The CENAPS Corp., PO Box 184, Hazel Crest, IL 60429. Ph: 708/335-3606.

ARTS AS PREVENTION: TELL THE STORIES AGAIN

Several years ago, I went to an Indian reservation to deliver a talk on health promotion. I went with flip charts and outlines and the latest figures on a host of diseases. As I concluded my remarks, an elderly gentleman stood up and said, "All the things you say have long been in our stories. We must simply love our children and tell them the stories again." He sat down. Though his remarks were brief, they struck me deeply.

This experience has stayed with me through the years. As I work in the field of prevention and health promotion, I wonder what we might be missing. Perhaps as we pursue our scientific analysis of problems, we need also to remember to make time for the stories.

In a larger sense, "telling the stories" refers to non-linear, intuitive processes, and their incorporation into program efforts. Creative artistic expression can take many shapes:

- myth and story-telling
- theater - formal and improvisational
- mime and humor
- dance and movement
- singing and other musical expression
- visual arts - including painting, pottery, sculpture

It is important to note that at times the arts can be used as a mechanism to carry cognitive messages, but sometimes it is the act of performing, creating and expressing that is, in and of itself, a productive and healing experience.

Unfortunately there is little research which demonstrates, or even addresses, the success of arts programs in reducing substance use and abuse. We need to build a conceptual framework and begin to document and systematically assess the effectiveness of strategies. To begin that process, I suggest we examine resiliency or protective factors which would theoretically be strengthened through the arts.

School Success. Research shows that school success is linked to strong verbal skills and the ability to communicate. Story telling can provide students with the opportunity to practice verbal communication and receive positive feedback. Better verbal skills also translate into better written work which, in turn, leads to better grades and hence, better success and bonding to school.

Positive Risk-taking. Many youth-at-risk seem to have an unusually high need for risk-taking and sensation seeking. Stage performance, whether theater, dance or musical, can provide a positive sensation and risk opportunity, thereby decreasing the need for these youth to seek such risks through alcohol/drug use and other self-destructive behaviors.

Ability to Express Emotions. When pain is deep, sometimes its expression can only be non-verbal. Unfortunately this often takes the form of interpersonal violence. Work with physical objects, such as clay, paint, and wood, can allow emotions to come through a physical channel and produce a positive outcome. Once the pain is registered and visible, it is easier for recovery and healing to begin. These same processes can augment the recognition and expression of positive emotional as well.

Exposure to Drug-Free Alternatives and Peers. The need to belong is strong in adolescence. Drug-free musical, theater, and dance troupes can provide that sense of belonging. They also provide the experience of positive, drug-free social activities and the natural high associated with rigorous extended physical activity.

Positive Role Models and Career Expectations. Involvement in creative projects links youth with positive role models who have learned to combine the discipline of the arts with the joy of expression. This can translate for youth into the development of increasing career expectations and bonding to society as they experience the rewards of working hard while participating in something of value to themselves and others.

Cultural Bonding. The arts have been a traditional means to pass on cultural values. Community "teatro", quilting or singing can help to create a sense of history, a sense of self, and a sense of bonding and belonging to a larger system. In some ways, the inclusion of arts in prevention/intervention would not merely result in a shift in program activities, requiring us to develop a new way to experience and interact with the world around us.

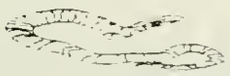
ARTS AS PREVENTION: TELL THE STORIES AGAIN (Continued)

The dominant cultural paradigm is scientific. It is reflected clearly in prevention research and practices to date. It can be characterized by values of precision, objectivity, linear processes, control as a desired outcome, order, and the pursuit of one right answer.

The artistic paradigm by contrast suggests and supports other values: immersion, subjectivity, abstract and random processes, understanding (not control as a desired outcome, spontaneity, expression, and the inclusion of multiple right answers.

The scientific paradigm has indeed allowed us to move forward; but cognitive processes can never take us all the way. As Ivan Ilich once said, "We cannot think our way to humanity." The Civil Rights movement resulted in legislation, but it began with a song. It is time to examine our prevention programs for balance between the scientific and artistic paradigms, to include the arts as an ally in prevention, and to begin to tell the stories again!

From: March/April 1990
Prevention Perspectives Newsletter



+ + + + + + + + + +

THE BOY AND THE SNAKE

Many years ago, Indian braves would go away in solitude to prepare for manhood. One hiked into a beautiful valley, green with trees, bright with flowers. There, as he looked up at the surrounding mountains, he noticed one rugged peak, capped with dazzling white snow.

I will test myself against that mountain, he thought. He put on his buffalo-hide shirt, threw his blanket over his shoulders and set off to climb the pinnacle.

When he reached the top, he stood on the rim of the world. He could see forever and his heart swelled with pride. Then he heard a rustle at his feet. Looking down, he saw a snake. Before he could move, the snake spoke.

"I am about to die," said the snake. "It is too cold for me up here and there is no food. Put me under your shirt and take me down to the valley."

"No," said the youth. "I know your kind. You are a rattlesnake. If I pick you up you will bite and your bite will kill me."

"Not so," said the snake. "I will treat you differently. If you do this for me, I will not harm you."

The youth resisted awhile, but this was a very persuasive snake. At last the youth tucked it under his shirt and carried it down to the valley. There he laid it down gently. Suddenly the snake coiled, rattled and leaped, biting him on the leg.

"But you promised...," cried the youth!

"You knew what I was when you picked me up," said the snake as it slithered away.

And now, wherever I go, I tell that story to young people who might be tempted by drugs. Remember the words of the snake: "You knew what I was when you picked me up."

Reprinted from Reader's Digest

+ + + + + + + + + +

IMPROVING THE ODDS: COMMUNITIES CAN FIGHT ALCOHOL AND DRUG ABUSE

Minorities are working to reduce the risks through community and parent programs, schools, and clinics. What we learned so far was reflected in Task Force recommendations. Here are a few of the approaches suggested:

- Help children and teenagers develop coping skills to delay or prevent smoking, drinking, and use of illicit drugs.
- Foster peer-group instruction in schools to strengthen resistance to alcohol, other drugs, and tobacco.
- Train health professionals increasingly in the diagnosis, prevention, and treatment of chemical dependency.
- Use culturally appropriate strategies. For example, Native American health programs should be planned in conjunction with the traditional medicine men of Native American society.
- Increase research on cirrhosis of the liver, alcohol and pregnancy, the epidemiology, etiology, and consequences of chemical dependence among minorities.

CROSSCUTTING TOPICS

CULTURAL TRADITIONS HELP IN THE WAR ON ALCOHOL, DRUGS

Different minority groups have different ways of coping with stress and adversity, noted the Task Force, and "coping patterns may play a crucial role in health outcome. An increasing body of research suggests that the ways an individual copes with stress and the resources available to resolve stressful situations, rather than the stressor itself, play the most important role in health outcome. In some minorities, traditional folk beliefs and culturally specific family patterns may affect their ability to withstand social, economic, and psychological stressors."

In other words, certain cultural traditions may help a person cope with stress that might otherwise be a factor in health problems, including abuse of alcohol and other drugs. For example:

- Asians and Pacific Islanders often "pride themselves on their independence and self-sufficiency. Consequently, some are particularly reluctant to seek health services, especially for mental illness or for counseling." The Task Force also commented that "the family is very important to many Asians," and that family reliance can strengthen an individual's social support resources, but it "may also pose a barrier to care when it is truly needed."
- Blacks traditionally "have placed great importance on kinship and family ties, which often form the basis of a network of mutual support...Also, the church is a powerful source of emotional strength for many Blacks." A hundred years ago, the Task Force noted, Blacks in the United States had lower rates of alcohol use than Whites, a tradition that may be reflected in the large numbers of abstainers among Blacks even today.
- Hispanics in the United States have a very strong family and community orientation." In addition, "the church and parish community are an important focus of family and social life for many Hispanics. In more rural settings, some Hispanics view the community as an extension of the family and feel that it has a protective and healing force that may be used to reinforce an individual's own coping skills."
- Native Americans have seen their traditional way of life disrupted, and "a sense of powerlessness and hopelessness has often been observed as a result and may be related to the high incidence of alcohol abuse, suicide, depression, and obesity among this population." But, the report continues, "American Indians...are also observed to draw upon traditional sources of strength to cope with stressors. Traditional strengths include the family, the tribe, and the land itself."

WHAT FACTORS MAKE KIDS AT RISK

Submitted to Prevention Pipeline

By: Andrea Funkhouser
Substance Abuse Education Coordinator
Okemos, Michigan

It has become quite common to talk about targeting "at-risk" students for substance abuse prevention programs. I submit that all students are at-risk and that we need to convince parents, educators, and the larger community that this is our real challenge.

I am frequently asked to go into the classroom as a guest speaker. My favorite topic is talking about **what factors make kids at risk for harmful involvement with not only alcohol and other drugs but also a variety of other problems - e.g. suicide, teen pregnancy, criminal activity, dropping out, etc. The following is the list of risk factors that I have generated (with help from students):**

- Alcoholic parent(s), grandparents(s), siblings(s), or other close family member;
- Divorced parents;
- Abuse in the home - physical, mental, emotional, sexual;
- Neglect in the home;
- Being adopted;
- Living in a blended family;
- Being new to a school;
- Being handicapped or chronically ill;
- Having learning problems;
- Having a chronically ill parent or sibling, or having a parent or sibling who has died;
- Having an emotionally distant father;
- Living in an emotionally repressive family;
- Being the child of a workaholic;
- Being the child of a perfectionist;
- Being a latchkey kid.

Once this list is generated, I ask the students if any of them have none of those factors in their lives. After talking to hundreds of students in our upper middle class suburban school district, I have yet to find a single student claim that none of those factors fit him/her.

All kids are at risk in this day and age. That needs to become the "group-think" of our society - especially those in prevention.

+ + + + + + + + + +

LOOKING FOR EXTERNAL CAUSES

Problems are not inside the person. Problems are inside an unjust society, George W. Albee, Ph.D., University of Vermont psychiatrist and prevention authority, stated at OSAP's Third National Learning Community Conference.

He believes we must focus on successful efforts at primary prevention to reduce problems afflicting our society. This means working with high-risk groups before they become casualties. He refers to high-risk individuals as socially marginal--victims of broken homes, poverty, prejudice, hopelessness, involuntary unemployment, exploitation, and other damages brought on by our society. To illustrate his point, Dr. Albee said if we could devise a prevention program of optimal choice, it would "ensure that every infant born was born wanted and full-term." For example, if pregnant mothers stopped using drugs, smoking, and/or ingesting alcohol, we would go a long way toward reducing all kinds of problems later, he held.

Dr. Albee does not feel psychotherapy plays a significant factor in bringing about the kind of change necessary. Instead, he says, the overall problem is the social environment we live in. "We should ask ourselves what are the causes of poverty, low self-esteem, boredom, and hopelessness. If we focus only on counseling to change self-esteem, we may fail to identify the causes."

After reviewing all significant prevention programs dating back to the 1970s, Dr. Albee designed a model for reducing the number of new cases of psychopathology in a given time period.

$$\frac{\text{incidence of psychopathology}}{\text{Prevention strategies}} = \frac{\text{organic factors} + \text{stress} + \text{exploitation}}{\text{social coping skills} + \text{self-esteem} + \text{support system}}$$

Supporting the basic principles of the public health model - involving the host, the agent, and the environment - the factors above the line in the diagram represent noxious agents that contribute to psychopathology including drug abuse. The factors below the line are ways we can strengthen the resistance of the host and thus prevent or ameliorate the behavior.

Among necessary ingredients for effective prevention programs, he said, are to 1) teach social coping skills at an age as early as preschool, 2) build self-esteem to empower people, and 3) provide support system that help make people feel they are part of a caring social network.

Dr. Albee founded the Vermont Conference on the Primary Prevention of Psychopathology, which has held an annual conference on prevention since 1975. Nearly 35 years ago, Dr. Albee produced a significant monograph in which he suggested several ideas that are being implemented today by many, including OSAP. He said we need to change those who provide services to persons in need, what kinds of services are being administered, the orientation of our interventions, and the social conditions that are producing the problems.

+ + + + + + + + + +

BODY AWARENESS RESOURCE NETWORK (BARN) is a computer-based system providing health information to adolescents....Major content ares: Body management, alcohol and other drugs, human sexuality, stress management, AIDS, and smoking....Field representatives, hired by Florida Informed Parents (FIP), will implement BARN in their counties. For more info contact: Karen Shephard, FIP, 2334 Capital Circle, NE, Suite 201, Tallahassee, FL 32308. Phone 904/385-7641.

From: Pulse Beats/Aug. 1990

BEYOND CURRICULUM: COMPREHENSIVE SUBSTANCE ABUSE PREVENTION

For years, we have approached substance abuse prevention as we have approached other content areas, by assuming that increasing students' knowledge about drugs would lead to changes of attitudes, and that those attitude changes would lead to changes of behavior. This curricular model attempts to persuade students who were considering alcohol and other drugs, or who had actually started abusing these substances, to say no.

Over the last twenty years, we have not seen this approach work consistently. Most studies evaluating curricular intervention show that curricula have no statistically significant effect on behavior. Furthermore, these studies show that many curricula have no significant effect on attitudes or even knowledge. Often, schools have implemented these curricula poorly, teachers haven't received adequate training, and programs did not have the time and scope to succeed. Finally, many prevention curricula operated in isolation, without cooperative programs that could provide a comprehensive effort.

These results show that an effective curriculum must move beyond the persuasion model and address a number of psychosocial skills. Appropriate curricula teach kids healthy behaviors and provide them with necessary skills by addressing issues such as positive self-esteem, decision-making and goal-setting skills, social pressures, critical analysis of media, self-discipline, empowerment, and responsibility. This approach starts in kindergarten, well before students are using or even considering using drugs, and it helps them determine how to make healthy choices and sustain those choices.

But a good curriculum is not enough. All too often, people assume that school curriculum is prevention. While a K-12 curriculum is an important component of any prevention program, an isolated curricular intervention can't hope to change kids' behavior in light of all the countervailing forces encouraging them to use alcohol and other drugs. To be successful, we need to support curricula with a number of other approaches that address other concerns.

So how can we move beyond curriculum? What are some other approaches? We believe that an effective prevention program must be comprehensive. Groups of people working cooperatively can have an impact. The Brown University Drug-Free Schools Program offers a comprehensive program consisting of seven components. The first program component involves establishing the philosophical foundations and goals for the program, guaranteeing coherence between the components. The next step is to move on to school climate. A difficult thing to define, school climate has a profound effect on students' sense of their environment. Social structures have changed so dramatically and rapidly that schools are no longer organized to respond to the needs of many students. These recent changes force students early and often to confront new, previously unconsidered issues such as substance abuse, often without the social structures that formerly would have provided support. We must incorporate the changes necessary to make our schools more appropriate for our youth and to provide a supportive, safe, healthy environment in which they can face the challenges of our society.

Student peer educators can also play a significant role in substance abuse prevention by assisting in the presentation of a comprehensive curriculum. Peer programs require the development of clear standards of behavior with which the peer educators must agree. They also require a careful recruitment, screening, and selection process, choosing applicants from various age groups. Finally, they must provide the peer educators with adequate direction, preparation, and support to insure the effectiveness of these programs.

Treatment-based services, such as Student Assistance Programs, are an essential part of any prevention program. They are comprehensive, integrated, school/community programs that provide student assessment, intervention, treatment, and aftercare services.

For obvious reasons, parents play the most important role in a child's development regarding substance abuse. Reinforcing program issues in the home can extend opportunities for discussion and support that schools alone can't hope to provide. Parent programs can address issues of general substance abuse awareness, parenting strategies, intervention and prevention methods, and the importance of drug-free activities.

Finally, we must consider providing attractive activities for students. Schools should develop alternative activities both for students who are drug-free and those who have become involved with drugs in an attempt to fulfill a legitimate social or personal need.

INTERVENTION SECTION

THE BATTLE AGAINST DWI: DAAA'S PROBLEM DRINKER DRIVER PROJECT

Despite great progress against the Driving While Intoxicated (DWI) problem in recent years, alcohol-related crashes remain one of the nation's leading causes of death.

And, because DWI/DWAI arrests make it possible to intervene and seek treatment for persons with alcohol problems, the Division is involved in a special research and education effort.

The Problem Drinker Driver Project (PDDP), a joint venture by the Office of Criminal Justice Services (OCJS) and the Research Institute on Alcoholism (RIA) in Buffalo, has developed a series of research papers and Research Notes on the DWI topic.

What emerges from these and other studies is a detailed portrait of the "typical" DWI/DWAI driver, as well as changing trends and new information on repeat offenders. For example:

10-12 Beers: The typical driver arrested for DWI/DWAI has been drinking in a bar and has consumed 10-12 beers. This despite the fact that it is against the law to serve: (a) a visibly intoxicated person, or (b) a "habitual drunkard" (archaic language for an alcoholic person).

BAC of .15: The typical DWI/DWAI driver also has a Blood Alcohol Concentration of .15, which equates to a 160 pound male consuming nine drinks in a two-hour period. This excessive consumption, indicating a high tolerance, is convincing evidence of a drinking problem.

Gaps in Screening: Only about half of the approximately 60,000 drivers convicted of DWI/DWAI in New York State choose to attend the Department of Motor Vehicles' Drinking Driver Program. The other half (possibly fearful of having their alcohol problem addressed) generally opt to take a license suspension for a time, then return to the roads.

High Volume: Although Convicted offenders make up only four percent of the licensed drivers, they now account for in excess of 20 percent of all convictions.

Criminal History: Persons with a history of crimes other than DWI are twice as likely to repeat as DWI offenders than are persons with DWI-only or with no criminal history.

Family Problems: Repeat offenders are more likely to be from families with alcohol problems, and families with DWI histories. Only about 15-18 percent of young DWI offenders have had alcoholism treatment.

Bar vs. Home: Compared to DWI offenders who drink at home, bar drinkers tend to have more drinks before their arrests, and are more likely to be binge drinkers.

Increase in Women: During the 1980s, the percent of DWI arrests involving women increased from 7.2 percent to 12 percent.

"The PDDP research significantly advances our understanding of how to attack this major public health problem," said DAAA Director **Marguerite T. Saunders.** "In order to make our roads safer, we must screen and treat more persons with apparent alcohol problems."

A proposal to increase screening and treatment of second offenders was sponsored by **Gov. Mario M. Cuomo** in the Legislature this year (A.6697 Bragman/S.6034 Libous). Unfortunately, the measure remained in committee in both houses.

The Problem Drinker Driver Project is funded by a grant from the Governor's Traffic Safety Committee (GTSC), and is co-directed by **William Williford, Ph.D.,** RIA's Deputy Director. Other participants include Research Scientists **Thomas H. Nochajski, M.A.,** and **William F. Wieczorek,** Ph.D., both of RIA; and **John Yu,** M.A. and **Dawn Essex,** M.A., of the OCJS.

Copies of the Research Notes may be obtained from DAAA's Office of Criminal Justice Services, 194 Washington Ave., Albany, NY 12210. As of mid-1990, 13 Notes had been published.

+ + + + + + + + +

MONTANA DUI OFFENDERS WHO COMPLETE THE ACT* PROGRAM DURING FY 87, FY 88, FY 89 AND FY 90

Compiled by the Highway Traffic Safety Division
with ACT data provided by the Alcohol and Drug Abuse Division

	FY 87	FY 88	FY 89	FY 90
Number of in-state DUI convictions	7,036	7,124	7,522	7,762
Less est. 7% out-of-state residence	493	499	527	543
Less 2.5% BIA	176	178	188	194
Total DUI offenders that should attend ACT	6,367	6,447	6,807	7,025
Number enrolled in ACT	5,066	4,877	4,750	5,049
Percent enrolled in ACT	80%	76%	70%	72%
Number completing ACT	4,336	4,203	4,136	4,465
Percent completing ACT	68%	65%	61%	63%
Percent of those who enrolled in ACT that completed ACT	86%	86%	87%	88%
Percent of those who enrolled in ACT that were recommended for treatment				
Outpatient treatment	31%	2%	29%	35%
Inpatient treatment	15%	4%	14%	9%

* In Montana, ACT is the name of the alcohol information course that all DUI offenders are required to take. The acronym stands for Assessment, Course, Treatment.

+ + + + + + + + + + +

TREATMENT

UPDATE ON TREATMENT PROGRAM:

Thunder Child Adolescent Treatment Program

Thunder Child Adolescent Treatment Program is the latest addition to the list of approved treatment programs in Montana. Opened in 1989 and located in Pryor, MT (Crow Indian Reservation), this free-standing inpatient program treats Native American adolescents. It is funded entirely with Indian Health Service monies and received referrals primarily from tribal health services both in Montana and other western states. Terry Beartusk is the Executive Director and Kathy Belden serves as Program Director.

The Thunder Child Adolescent program is a 16-bed unit. Treatment philosophy centers around the AA 12 steps and incorporates Native American spiritual and cultural traditions. Patients are in residential treatment approximately 40 days after which they are referred to an outpatient program for aftercare. Ancillary services necessary to treatment i.e. psychological, medical, vocational are available in Billings which is 40 miles away; some of these are provided on a routine basis through individual contracts for services.

The program has experienced the usual "newborn" growing pains but is now in full compliance with Montana standards for inpatient free-standing treatment.

The Red Canyon Ranch

The Rocky Mountain Treatment Center has opened a new primary treatment program for young women. The Red Canyon Ranch opened this summer and has recently received its initial 6-month approval.

The Red Canyon Ranch is a 4,800 acre ranch located in the foothills of the Snowy Mountains, east of Lewistown. The program has been developed for young women ages 13 to 24 who have been assessed as needing treatment for the addictive disorders of chemical dependency, co-dependency, and eating disorders. This program incorporates traditional treatment with an unique equestrian element of therapeutic riding.

Additional services are provided through arrangements with Lewistown Alcohol and Drug Services, Lewistown Mental Health Center and Central Montana Hospital.

+ + + + + + + + + +

Glacier View Hospital

Treatment Partnership for Alcohol and Drug Services in Valley Formed

In June, Glacier View Hospital announced formation of a treatment partnership involving its Life Works alcohol and drug program, Ken Anderson, director of the Flathead Valley Chemical Dependency Clinic and John Brekke of the Wilderness Treatment Center.

Brent Porges, Glacier View administrator, said "for the past several years all three programs have discussed the feasibility and benefits to the community of forming a partnership that would coordinate complementary treatment services and centralize management."

Glacier View Hospital has provided inpatient alcohol and drug treatment services since 1985. Nearby Flathead Valley Chemical Dependency Clinic has provided the area with comprehensive outpatient services since 1978, while the Wilderness Treatment Center has provided a unique outdoor treatment program for males ages 14-25 since 1983.

According to Ken Anderson, director, Flathead Valley Chemical Dependency Clinic, "The three treatment programs have created an arrangement that will result in provision of a comprehensive continuum of care for both inpatient and outpatient services that will provide the most appropriate, cost effective level of care to persons needing help."

Under provisions of this agreement, Glacier View Hospital has contracted with Health Management Corp. (HMC) to manage operation of its Life Works program effective July 1.

MHC is a management organization formed by Anderson and John Brekke, Executive Director of the Wilderness Treatment Center.

Mike DuHoux was appointed director of the Life Works program and is responsible for coordination and implementation of all alcohol and drug treatment services provided by Glacier View.

+ + + + + + + + + +

ART AS THERAPY

Last summer, through the generosity of an anonymous donor and the Montana Arts Council, I had the opportunity to make art twelve hours a week for five weeks with emotionally disturbed teenagers residing at Missoula Youth Homes' Susan Talbot Centers I and II. In the spring, while discussing the possibility of such a residence, Program Director Sally Stansberry and I established broad goals. We wanted to provide a safe and secure environment in which troubled youth would have the opportunity to practice the process of making art as an experientially valid method of self-exploration and expression toward increased self-esteem. We further intended the residence to support the therapeutic constructs designed for the treatment of each youth involved. And we wanted the kids to enjoy making art.

Sixty hours of residency. Ten teenagers. Studio space transmuted from ping-pong room and storage shed. How to get the youth to forego one set of cognitive habits long enough to move into the place in their heads/hearts where art starts? Drawing on experiences in yoga, biofeedback, Waldorf reaching methods, and twenty years of my own experiments in making cognitive shifts, I designed a set of focus exercises which would hopefully become sensory cues.

Taste-touch-smell-hearing, eyes closed, deep breathing, setting still in sunlight. Fresh finger-lave-sage smoke-clear tonal music. Let your thoughts move through you like fishes through water. Open eyes, stand, slowly enter one standing balance posture, slowly relax. Turn to your art. Without speaking, without thinking in words, turn to your work.

Bill Stansberry, Therapy Co-ordinator for the Talbot Centers, selected the youth whose treatment needs he felt would be most supported by involvement in the studios. Due to behavioral problems often in evidence by troubled youth, studios were kept small, no more than three young people at a time. This meant we could provide ten studios, an hour and a half in length, twice a week, for each youth. In combination with the focus exercises, opportunity for intensive engagement with art-making, I hoped the frequency, regularity and structure of the studios would create an artistic "training effect" similar to that experienced by persons with regular exercise habits.

We use direct materials: charcoal, pastel, crayon, plaster, sand, found objects, eventually acrylic paints and media. We work on a variety of surfaces, eventually each youth building, carving, sawing, gouging upon a personal "wall", a two foot by four foot section of drywall. Inventing texture. For eight of the ten sessions, compliance, a drifting in and out of focus.

I show how to use materials by working on my own piece, I don't criticize. I look when I am invited, I don't analyze. In the studio, there is no confrontation. "Do you know what it means?" they say. I say, "To me, maybe. To you, not unless you tell me." This seems a satisfactory and reassuring response, not to mention honest. And then, suddenly, almost all at once, they engage.

They make courageous art. They ask for an extra studio. They get it.

We have an exhibition, for staff, therapists, family. For their sakes we include a mini-studio, and the building of "trouble-bundles" of sticks and leather to represent the troubles we are willing to let go of. We burn these, together, in a bonfire. Focus, making, letting-go, closure.

Most of the kids chose art and music classes in school this fall. Both houses have established permanent space where youth may make art individually. Each teenager involved asked when the studios would begin again.

Nobody had a Damascus Road experience. Everybody still has problems.

And everybody wants more paint, next time, and next time, clay. We can work it more, they explain. We can move it around. We can decide to make a change without having to start over.

I think we met our goals.

+ + + + + + + + + +

TREATMENT AND COUNSELING CONSIDERATIONS

The Alcohol Services of Gallatin County has compiled a list of treatment considerations that people should keep in mind when choosing a treatment program.

TREATMENT CONSIDERATIONS

1) Treatment Philosophy
   - a) Abstinence based?
   - b) Disease concept?
   - c) Supportive of 12-Step Recovery Programs?
   - d) Individualized Treatment Planning?
   - e) Whole Person Concept?
   - f) Ability to evaluate and counsel and/or refer for other problems?
   - g) Group v. Individual Counseling or mixture of both?
   - h) Family involvement?
   - i) Aftercare services?
   - j) Criteria for admission - to program? Inpatient vs. Outpatient?

2) TREATMENT CREDENTIALS AND STAFFING
   - a) Licensing; State Approved: JCAHO
   - b) Staff qualification; Certified Chemical Dependency Counselors

Treatment & Counseling Considerations (Continued)

c) Variety of staff available? Males, Females, Experience in field?
d) Specialty groups? Adolescent, Male, Female, Elderly, Gay
e) Frequency of counselor contact with client
f) Counselor to client ratio

3) CURRENT CLIENT DEMOGRAPHICS
a) Average age
b) Male vs. Female ratio
c) Minimum/Maximum group size
d) Group size

4) SERVICE FEES
a) Covered by Insurance?
b) Sliding Fee Scale
c) Payment plan available?
d) Does facility appear client or dollar focused

They also have compiled counseling considerations:

1) Counselor Certified/Licensed in area you are seeking help
2) Counselor addresses your needs vs. telling you what you need
3) Counselor works both on a group and individual basis
4) Counselor able to direct you to your answers vs. having answers for you
5) Counselor respectful of your needs, wants, and fears
6) Counselor client focused vs. dollar focused
7) Criteria for individual vs. group?
8) Criteria for length of counseling?

++++++++++

GENERAL OFFICE OF NATIONAL DRUG CONTROL POLICY (ONDCP) released a "white paper" on drug treatment to describe in layman's terms what treatment is and what's currently known about treatment -- what works and what doesn't. While the report acknowledges that "drug treatment will play a large role in our national drug reduction efforts in the months and years ahead," it doesn't embrace goal of treatment on demand nor does it wholeheartedly endorse disease concept of addiction.

From: Pulse Beats/August 1990

++++++++++

HELPING WOMEN WITH AOD PROBLEMS

"Before a woman became a substance abuser, she was first a woman," said Norma Finkelstein, Ph.D., Director of the Coalition on Addiction, Pregnancy, and Parenting in Boston, MA. This premise should guide the operation of any program that treats women for alcoholism or other drug dependence, she held.

Her workshop on treatment programs for women was one of over a hundred workshops conducted at OSAP's Third National Learning Community Conference focusing on Substance Abuse Prevention Among High Risk Youth and Pregnant and Postpartum Women and Their Infants.

Dr. Finkelstein's workshop on "What We Have Learned About the Empowerment of Women & Treatment Systems Sensitive to Women's Issues" reflected her 15 years of experience as the director of a federally funded program treating women with alcohol and other drug problems. She emphasized the importance of treating these problems in the context of all issues a woman must face, which are likely to include poverty, unequal opportunity, and single parenthood.

Contrary to common belief, Dr. Finkelstein does not recommend forbidding women in treatment to maintain a relationship or develop new ones while recovering. "If you take relationships out of treatment, you are then not helping the woman learn how to have healthy relationships. Why not bring the relationship into treatment?" She does however, recommend encouraging women to leave unhealthy friendships and abusive partners.

The focus on relationships comes from a developmental model developed at the Stone Center at Wellesley College by Dr. Jean Baker-Miller in, "Toward a New Psychology for Women." This model was designed as an alternative to the traditional male model, in which the healthy development of the person is described in terms of individuation or separation. In that model, women are often seen as dependent and therefore unhealthy.

"The Stone Center's Self and Relation Model defines healthy development for the woman in terms of the relationships she forms," says Dr. Finkelstein.

"Problems for women arise when there is a 'disconnection' in their relationships. This disconnection may take the form of family violence, sexual abuse, or incest," she says. To empower women recovering from substance abuse, according to Dr. Finkelstein, programs should use the Women's Alcoholism Program's model and treat women in a multigenerational context, including the family of the woman's childhood, her current relationship with spouse or other, and her relationship with her children. A woman who abuses alcohol or other drugs often suffers an extra burden of guilt if she perceives that her addiction means that she is a failure as a mother. She says that women are more likely to pursue treatment that addresses family issues and includes the family in the treatment.

Issues discussed included: housing for women in treatment, modeling behavior that builds self-esteem, support networks for recovering women, attitudes of caregivers toward women substance abusers, criminalization and other legal issues affecting addicted women, exposure of infants to alcohol and other drugs, and protection of children in dysfunctional families.

The Coalition on Addiction, Pregnancy, and Parenting at the Massachusetts Health Research Institute was recently funded by the Office for Substance Abuse Prevention.

++++++++++

OFFICE FOR TREATMENT IMPROVEMENT ISSUES MISSION STATEMENT

In June, the recently established Office for Treatment Improvement (OTI), a fifth component now located within ADAMHA (along with NIMH, NIAAA, NIDA, and OSAP), issues its mission statement. According to this document, OTI's goal is to improve "drug treatment programs for special populations." Currently, OTI's focus is on racial/ ethnic minorities, adolescents, individuals living in public housing, and individuals involved in the criminal justice system. Furthermore, OTI has "a special interest in enhancing the role of drug treatment in the Nation's health care system...and in reducing community barriers for the establishment of expansion of drug treatment." The main message of OTI is that "drug treatment works."

To date, OTI's missions are to 1) manage the alcohol, drug abuse, and mental health block grant program, 2) operate a treatment improvement grant program, 3) conduct technical assistance workshops, 4) support technology transfer, and 5) encourage the implementation of quality assurance mechanisms in treatment programs.

For more information about the activities or goals of OTI, contact Joan Hurley, Acting Director, Public and Constituent Affairs, OTI, 5600 Fishers Lane, Rockwall II, 10th Floor, Rockville, MD 20857, (301) 443-4962.

++++++++++

CALIFORNIA'S GATEWAY PROGRAM

What began as an after-school program for latchkey children has evolved into a powerful clinical tool for treating youth in high-risk environments, said Miguel Firpi of the junior high school recreation program in Richmond, CA at OSAP's Third National Learning Community Conference.

The OSAP-funded recreational program was intended to give students - who live in one of the poorest communities in the Bay Area - an alternative to streets overrun with crack and gangs. As part of the three-pronged Gateway Program, which offers traditional therapy and social services, the recreation program also began to serve other purposes. Its emphasis on fun, group-oriented activities helped to attract reluctant youth into the larger Gateway Program, where students could receive individual and group counseling,

In addition, the program became a behavioral lab; a safe, regulated environment where students could learn new ways of interacting with others, said Firpi, Director of the Gateway Junior High School Program.

"Everything done in recreation has a clinical purpose," he explained. "The individual counselor instructs the recreation team of the youth's problem, and the team structures activities around the child's problem."

Each weekday session involves drama, sports, or art activities and two group sessions. Participating in rituals, "trust" games, and journal-writing gives students a forum for talking freely about their families and school problems. They also go on monthly outings and a summer wilderness trip that serves as a graduation from the year-long program.

Students say they like Gateway because it provides for a family structure lacking in their home lives. Former gang members join the program for similar reasons. "Our program is oriented toward providing for the same emotional and family needs that gangs fulfill," said Firpi. "Students have their own T-shirts and they are clearly identified in school. They have developed a sense of pride and belonging in being Gateway kids, and so they've turned into a sort of healthy 'quasi-gang' themselves."

Over 300 children now take part in the program, more than twice the number expected when Gateway first received OSAP funding in 1987. The program will continue to expand with the assistance of another OSAP grant, awarded in October 1989. Several elementary schools plan to implement similar programs.

+ + + + + + + + + +

PREGNANT ADDICTS PROVOKE LEGAL, ETHICAL ISSUES

Women who use drugs during pregnancy have encountered one of three responses from this society: criminal prosecution, intervention from a child protection agency, or therapy. Each approach to dealing with addicted pregnant women involves difficult legal, medical, and ethical decisions, stated Wendy Chavkin, M.D., M.P.H. in a workshop at OSAP's Third National Learning Community Conference.

Dr. Chavkin, of Columbia Presbyterian and Beth Israel Medical Centers in New York City, pointed out that criminal prosecution, though rare, receives the most media attention. She cited the case of Pamela Stewart, whose baby died after delivery, and the more recent trial of Jennifer Johnson, who was charged with transferring cocaine to her baby via the umbilical cord immediately after delivery.

Stewart's case was "basically thrown out because the criminal child abuse statutes were seen as inapplicable to the fetus," said Chavkin. "Attempts to prosecute have mostly foundered on the fact that the fetus is not accorded the status of a citizen."

Johnson was convicted of giving drugs to a minor-a felony conviction usually reserved for drug dealers. "This effort to invoke criminal sanctions is fueled by two opposite ways of thinking that are going on in this country right now," explained Dr. Chavkin. "They reflect a century-old dispute as to whether drug use is willful criminal behavior or whether it is an illness."

She asserted that "although several Supreme Court decisions have affirmed that drug use is an illness, the national drug policy seems to reflect the view that drug use is criminal behavior."

The second major response to addicted pregnant women-the invocation of the child abuse and neglect apparatus-often results in "holding poor people accountable for their poverty" rather than reuniting the family, said Dr. Chavkin. She believes the system punishes women for not providing adequate environments for their children, but does little to alleviate the problem.

Intervention from child protection agencies takes many forms, depending on the laws governing each State. New York State defines a chronic parental intoxication resulting in a child's functional impairment as neglect, and accepts a positive newborn urine toxicology test as evidence of neglect. Infants who test positive are referred to child protection

agencies. The result has been a swell in the number of boarder babies - over 300 per day of them in New York City hospitals for an average of 2 months, according to a survey Dr. Chavkin conducted 3 years ago. Forty percent were discharged to their biological families without having necessarily received any social services.

A similar survey last year revealed that the system has become increasingly overburdened. The 300 boarders stayed an average of 1 week in the hospital, rather than 2 months, and another 140 babies lived in congregate care facilities. Half of these infants tested positive on the urine toxicology exam; the others were held because of maternal homelessness, also considered neglect under New York State law.

"My understanding is that the world of child protection occupies a peculiar legal bubble," said Dr. Chavkin. "Because the underlying ideology of the model is that it is in the best interest of the child, legal safeguards for the parents have been curtailed in a fashion that they have not been in any other situation."

Existing treatment programs have been a limited option for addicted pregnant women, she held. In a survey of New York City treatment programs last year over 50 percent of the clinics refused to enroll pregnant women. Nearly 90 percent refused pregnant women on Medicaid who were addicted to crack.

In the medical realm, some treatment centers are unclear about treatment and detoxification during pregnancy. Rehabilitation centers have been crippled by " lack of attunement to addicted women together with the medical confusion over how to treat pregnancy and addiction simultaneously," said Dr. Chavkin. However, progress has been reported in programs that attempt to provide comprehensive services for pregnant drug-using women.

+ + + + + + + + + +

RESEARCH SHEDS LIGHT ON ALCOHOLISM

New information has emerged that has clarified why females, after consuming comparable amounts of alcohol, often have higher blood alcohol concentrations than men - even after size differences are calculated. It has been discovered that females have a much reduced "first-pass" metabolism of alcohol compared to men. First-pass metabolism refers to the alcohol degradation by alcohol drhydrogenase (ADH) that occurs in the stomach (in contrast to the majority of ADH activity normally associated with the liver).

Non-alcoholic females and males were tested. The females exhibited only 23 percent of first-pass metabolism and 59 percent of the gastric alcohol drhydrogenase in comparison with the men. Differences were also found in alcoholic females and males where alcohol drhydrogenase activity was further reduced (by half) in men and was virtually absent in women. These conclusions help us understand why women may be more vulnerable to both short-term and long-term effects of alcoholism because of increased blood alcohol levels (and therefore a more chronic liver exposure) due to a much reduced first-pass elimination of ethyl alcohol.

HEADLINES AND GENES

In mid-April (precisely two days after my deadline for the June "Slice" column), articles appeared in the **Journal of the American Medical Association (JAMA), The Wall Street Journal, The New York Times, Science News,** the **Chicago Tribune**, and the **Atlanta Journal & Constitution with these headlines:**

- **"Finding the Gene(s) For Alcoholism"**
- **"Allelic Association of Human Dopamine D2 Receptor Gene in Alcoholism"**
- **"Alcoholism is Linked to a Gene"**
- **"Scientists See a Link Between Alcoholism and a Specific Gene"**
- **"Gene May Be Tied to 'Virulent' Alcoholism"**
- **"A Promising Clue to Alcoholism"**
- **"Researchers Report Finding Gene That Can Play Role in Alcoholism"**

Researchers at the University of California, Los Angeles, and the University of Texas, San Antonio, announced the results of a small but very sophisticated study that associated one of two known human dopamine receptor genes with the expression of alcoholism. In the samples of brain tissue (35 in all), the presence of this gene correctly classified 77 percent of alcoholics and was found in only 28 percent of nonalcoholics. A background in molecular biology, specifically genetic engineering technology, is necessary to appreciate the scientific method employed and reported in the complete paper; however, the editorial "Finding the Gene(s) for Alcoholism" in the April 18 issue of JAMA provides an excellent (and more understandable) review.

PROMISE AND CAUTION

There are at least two important aspects relative to the announcements made by this research group. One tempers the other. First, there is incredible promise found in this most recent step, which again offers sound evidence for the existence of (at least in part) a genetically determined aspect (or form) of alcoholism. It is also based on previously recognized scientific information that copamine, as a neurotransmitter, helps control pleasure-seeking behavior or "reward" and is strongly implicated in the mechanism or physiology of cocaine addiction. There is promise also (in forward-thinking scientific terms!) that by pinpointing the receptor sites, it may be possible to: (1) try to block the gene action to help interrupt the addiction cycle; or (2) develop a simple blood test or assay for risk based on the presence of the alcoholism gene, thus expanding prevention and treatment efforts.

The second aspect is one of caution expressed by the authors of the research and by any reliable reporter sensitive to the misplaced enthusiasm sometimes surrounding the announcements of scientific research-caution in that the study needs to be repeated with a larger clinical group, peer review questions need to be satisfied, and that both the research and the disease of alcoholism are extremely complex. The JAMA editorial reminds us that alcoholism appears to be at least clinically heterogeneous-having many manifestations. Therefore, at best, we have new insight into just a portion of the biological and sociological interaction between genes, environment, and the psychology of humans and their relationship with alcohol.

In the final analysis, addiction science is beginning to mature and much specific evidence has begun to appear that support what many professionals suspected from clinical or field experience for a longer period of time. Those looking for the simple or singular answer to addiction, however, will not find much solace. It appears that the development of alcoholism and other drug addictions is not a case of genetics versus the environment; it is one of genetics and the environment. One of the most exciting aspects as the details of addiction are unraveled is their potential role in the guidance and development of more effective strategies in prevention, intervention, and treatment.

+ + + + + + + + + +

DRUG TESTING GAINS IN POPULARITY

The results of a survey completed by the New York based American Management Association were released in March 1991. One thousand six hundred companies were surveyed nationwide in January of this year. Of those responding, 63% said they were doing some type of drug testing. That number was up from 52% one year ago. There has also been an increase in the number of companies doing random drug testing. One year ago only 10% of those surveyed did random testing. This year the number had risen to 20%. Over one third of the respondents tested their employees only when there was a reason to suspect drug use ("for cause testing"). The yield on this type of testing was extremely high. 27% of individuals tested "for cause," tested positive for drug abuse.

COMMENT: These results have not been repeated elsewhere. According to the Federal Railroad Administration, last year only 3.2% of randomly tested railroad workers were positive. Only 2.2% were positive when "testing for cause" (down from 5.4% in 1988).

From: The Forensic Drug Abuse Advisor
May, 1991

+ + + + + + + + + +

CHEMICAL DEPENDENCY COUNSELOR
CERTIFICATION FY 90
(July 1, 1989 - June 30, 1990)

▸	Registered	168
▸	Applications/Submissions	115
▸	Certified	56
▸	Renewed	89
▸	Suspended	36

TESTS ADMINISTERED

	#	% Passed
Written Exam	138	69%
Oral Exam	210	45%
Tape Reviews (reviewed 211 tapes)	148	47%

665 Certified since 1981
137 Certificates Suspended

528 Currently Certified

/ / / / / / / / / /

CERTIFICATION

Congratulations to the newly certified Chemical Dependency Counselors. The following individuals have been certified since the last Habit publication.

Vera Parker
Jerry Smith
Dee Lundberg
Sheila (Gapay) Herman
Dennis Latka
Simone Azure
Judith Anderson
Mark Gilbert
Meg Bennett
Joseph D. Boyle
Phillip Tambornino
Dave Wysoski
Ralph Boerner
Beatrice Arroe-Siner
Karla Jones
Eden Beckwith
Mary Weaving
Marcia Landes
Michele Tesar
Gary Frost
Bonnie Frey
Valerie Dunn
Clarissa Waller
Roberta Crane
Margie Mettler
Donna Gruhler
Carol Highland
Debra Carper

Lynnette Kennedy
Willie Brown
Granger Brown
Tim Wall
James E. Barrett
Derek Dalton
Sandra S. Kitts
Cordelia Slater
Virginia Gross
Michael Dempsey
Allen Dahl
Lola Lyle
Linda K. Meyer
Rebecca Lane
Judy Thomas
Loren Johnson
Naomi Lev
Bob Stickney
Marilyn Kananen
Sandra Collins
Patricia McClure
Judy Ekberg
Cyndi Hoverson
Cindie Jobe-Schaul
Nancy Hawkins-Semenza
Tom Camel
Carmen Lousen
JoAnn Graves-Gill
Dennis Shaw

Tentative Counselor Certification Exam Schedule (1991)

WRITTEN EXAM	70 POINTS DOCUMENTED BY
January 11, 1991 - Billings	November 9, 1990
January 19, 1991 - Helena	November 9, 1990
May 10, 1991 - Billings	March 8, 1991
May 11, 1991 - Helena	March 8, 1991
September 13, 1991 - Billings	July 12, 1991
September 14, 1991 - Helena	July 12, 1991

ORAL EXAM

January 17-18, 1991
February 21-22, 1991
June 27-28, 1991
October 24-25, 1991

TAPE REVIEWS	TAPES DUE
March 21-22, 1991	March 8, 1991
May 2-3, 1991	April 19, 1991
July 25-26, 1991	July 12, 1991
November 21-22, 1991	November 8, 1991

+ + + + + + + + + +

Recently our office received the evaluations and comments from participants following an Assessment and Evaluation workshop. One individual, who is currently in the process to become a Certified Chemical Dependency Counselor, wrote that the workshop was ". . . aimed at the professional -- with assumed knowledge in the area, not accounting for us 'rookies'". There is clearly some misunderstanding about what the certification system is and who should apply for this certificate.

In 1980 the Department of Institutions, as a result of legislation, developed a process whereby counselors working in state-approved treatment programs would be required to complete a series of exams to ensure competency in the field of chemical dependency. The certification process is a competency-based system, designed to test for the skills and knowledges required to provide counseling services to chemically dependent individuals and their families. There is an assumption that individuals entering the system have, prior to registration, received formalized training, not only in chemical dependency but also the skills necessary to provide counseling services.

Over the last few years the Alcohol and Drug Abuse Division has experienced a great influx of people who view the certification system as a training ground for the chemical dependency counseling profession. Many individuals, who have not received the necessary training, are experiencing a great deal of frustration in the system. Some view the Division as having the responsibility to provide this training, usually after they have failed one or more of the exams. Often we have calls from people saying that it is too "costly" to go to a training program. This is much like saying one wants to be a brain surgeon but doesn't want to pay for the education; they'll just take the test and expect to be successful. There are a number of one-year training programs available in Montana for individuals interested in becoming chemical dependency professionals. They do, however, require a commitment of time and money. One should not expect to be successful in the certification system without formalized training any more than one could expect to pass the bar exam without going to law school.

One problem the Division is experiencing is with community volunteers working in school prevention programs applying for certification as counselors. Although many of these applicants have received training in prevention of chemical dependency in adolescents, most have not received formalized training in addition or counseling methods. Lacking this knowledge and skill, many will fail the experiential exams.

We also have a large number of people from other professions entering the certification system who indicate they simply want to add the CD certificate to their credentials, and who have not received specific training in chemical dependency. Many people from various fields such as probation and parole officers, teachers, nurses, rehabilitation counselors, social workers and mental health workers, who do not have specific training in chemical dependency, are also being frustrated by failing the certification exams.

Chemical dependency counseling is a specific profession and individuals interested in a career in this field need to make the commitment, of time and money, to obtain the training required for any professional license or certificate. The CD certification system is a competency-based testing process, designed to test for the knowledge and skills necessary to provide professional counseling. Individuals registering for certification are expected to have already obtained the training necessary to successfully complete the exams and be qualified to provide professional counseling services to chemically dependent people and their families - - prior to registering for certification.

+ + + + + + + + + +

A new effort called Veterans Against Drugs (VAD) seeks to reduce the use of drugs through the participation of veterans in the efforts of fighting drugs and encouraging drug-free lives. The National Crime Prevention Council is supporting the startup efforts of VAD. As part of this effort, we are attempting to identify those veterans groups and individual veterans who have carried out activities, programs, changed policy, or otherwise acted to reduce the supply of use of drugs.

If you have any information regarding any one veteran or any veterans group carrying on the effort, please call the National Crime Prevention Council at: 202/466-NCPC

The Habit routinely publishes articles or excerpts from articles that appear in nationally distributed publications primarily in the field of chemical dependency. Such articles are solely intended to be informational services to our readers and to make them aware of current trends and opinions on issues relating to chemical dependency. Such articles do not necessarily reflect the opinions or policy of the Alcohol and Drug Abuse Division. Suggestions for noteworthy articles or opposing views to articles published are welcomed.

ALCOHOL AND DRUG ABUSE DIVISION

500 copies of this publication were produced at a unit cost of $.69 per copy, for a total cost of $360.69, which includes $305.81 for printing and $54.88 for distribution.

Alcohol and Drug Abuse Division
1539 11th Avenue
Helena, MT 59620

Bulk Rate
U.S. Postage
Paid
Permit No. 89
Helena, MT